EXHIBIT

C

1004784 0-831-475-1
Step 2 CK Request Form

UNITED STATES MEDICAL LICENSING EXAMINATION™ (USMLE™)

RECEIVED
JUL 07 2005
Disability Services

Step 1 and Step 2 Clinical Knowledge
Applicant's Request for Test Accommodations

You MUST provide supporting documentation verifying your functional impairment.
In order to document your need for accommodation as completely as possible, please attach:

- **Evaluation reports of appropriate professionals printed on letterhead and signed by the evaluator(s)**
- **Primary documentation (report cards, teacher notes, behavioral observations, medical records, lab reports, etc.)**
- **A personal statement describing your disability and it's impact on your daily life and educational functioning. Do not confine your comments to standardized test performance; rather discuss your overall functioning.**
- **Read documentation information on page 4.**

Please note: NBME will acknowledge receipt of your request and audit your request for completeness. Submission of incomplete or illegible request forms and/or insufficient supporting documentation will slow the processing of your request. You may be asked to complete your request in a timely manner by submitting additional documentation.

Information regarding the granting or denial of test accommodations will not be released via telephone. All official communications regarding your request will be made in writing. Should you wish to modify or withdraw a request for test accommodations, please contact Disability Services at 215-590-9509.

Please type or print.

Accommodations are requested for the following Step examination (Use a separate form for each exam):
☐ Step 1 ☑ Step 2 Clinical Knowledge ☐ Step 2 Clinical Skills Year: 2005

Section A: Biographical Information

1. Name: Katz (Last) Richard (First) D (Middle Initial)
2. Gender: ✓ Male Female
3. Date of Birth: 03/16/70
4. SS# 055-70-7526 (if known)
5. USMLE # 0-631-475-1
6. Address: 90-50 Union Tpke. Apt. 18H
   Street
   Glendale NY 11385
   City State/Province Zip/Postal Code
   USA
   Country
   (718) 974-3718
   Daytime Telephone Number
   (718) 847-2823
   Alternate Telephone Number
   E-mail address
   Cat2400@msn.com
7. Medical School: St. Christopher's College of Medicine

(Over)

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Section B: Nature of Disability

8. Indicate the **nature of the disability** and the **year** it was first professionally diagnosed (select all that apply):

Sensory Impairments:
- ☐ Hearing Disability _____
- ☐ Visual Disability _____

Learning Impairments:
- ☐ Reading Disability _____
- ☐ Writing Disability _____
- ☐ Mathematics Disability _____
- ☐ Other: _____

Language Impairments:
- ☐ Receptive Language Disorder _____
- ☐ Expressive Language Disorder _____
- ☐ Mixed Receptive/Expressive Language Disorder _____
- ☐ Other: _____

Medical Impairments:
- ☐ Mobility/Motor _____
- ☐ Diabetes/Thyroid Dysfunction _____
- ☐ Epilepsy/Neurological _____
- ☐ Other: _____

Mental Health /Executive Function Impairments:
- ☑ Anxiety Disorder _____
- ☑ Mood Disorder/ Depression _____
- ☑ Attention Deficit Hyperactivity Disorder 2005
- ☐ Other: _____

Section C: Accommodations Information

10. What accommodation(s) are you requesting? Accommodation(s) must be appropriate to the disability:

Additional Break Time – over 2 days

Additional Testing Time – Double Time

11. If you are requesting additional testing or break time, please indicate the amount of time requested (circle no more than one per Step).

STEP 1:

- ☐ Additional Break Time over 1 day
- ☐ Additional Break Time over 2 days
- ☐ Additional Testing Time – Time and one-half
- ☐ Additional Testing Time – Double Time
- ☐ Other (please specify): _____

(Continued on the next page)

STEP 2:

☑ Additional Break Time over 2 days ☐ Additional Testing Time – Time and one-half
☑ Additional Testing Time – Double Time
☐ Other (please specify): _____

12. Do you require wheelchair access at the examination facility?

☐ yes ☑ no

If you require an adjustable height table, please indicate the number of inches from the floor: _____

Section D: Accommodation History

13. Prior classroom or test accommodations that you have received:

A. Standardized Examinations ☐ yes ☑ no

Medical College Admission Test (MCAT):

Month/Year _____

Accommodation received _____

(If extra time, note amount given _____)

Other:

Month/Year _____

Accommodation received _____

(If extra time, note amount given _____)

B. Medical School ☐ yes ☑ no

Accommodation received _____

Date Approved _____

If yes, have an appropriate official at your medical school complete the Certification of Prior Test Accommodations form.

C. College ☑ yes ☐ no

If yes, accommodations received Extended Time for Exams

D. Secondary or elementary school ☑ yes ☐ no

If yes, accommodations received Exempt during Class time for Speech Therapy with Speech pathologist weekly.

(Over)

14. Authorization:

I authorize the National Board of Medical Examiners (NBME) to contact the entities identified in Section D of this request form, and the professionals identified in the documentation I am submitting in connection with it, to obtain any or all of the following: confirmation, clarification, and/or further information. I authorize such entities and professionals to provide NBME with all requested confirmation, clarification, and further information.

Signature: _____ Date: 06/06/05

DO NOT SUBMIT:

- Original documents; keep the original and submit a copy
- Research articles, resumes, curriculum vitas
- Handwritten letters from physicians or evaluators
- Handwritten letters from physicians or evaluators
- Documentation previously submitted to Disability Services
- Documentation previously submitted to your registration entity
- Previous correspondence from Disability Services
- Multiple copies of documentation (i.e., faxed and mailed copies of a document)
- Staples, clips, binders, page protectors, folders, or similar items

Please note that submitting duplicate documentation and/or bound documentation may delay a decision regarding your request as all documentation must be processed.

DO SUBMIT:

- Legible copies
- All documents in English. You are responsible for providing certified English translations of foreign-language documentation
- Typed or printed letters and reports from evaluators
- Documentation from childhood if you are requesting accommodations based on a developmental disorder, i.e. LD, ADHD, Dyslexia
- Documentation of your functional impairment in activities beyond test-taking
- Documentation of your functional impairment beyond self-report

Mail your completed questionnaire and documents to:

Students / Graduates of US & Canadian Medical Schools
Testing Coordinator, Disability Services, National Board of Medical Examiners,
3750 Market Street, Philadelphia, PA 19104-3190.
215-590-9509

Students / Graduates of International Medical Schools
Test Accommodations Coordinator, Educational Commission for Foreign Medical Graduates
3624 Market Street, Philadelphia, PA 19104 USA.

Please keep a copy of your completed request form for your records.